Complete Summary

TITLE

Chronic stable coronary artery disease: percentage of patients who also have diabetes and/or LVSD who were prescribed ACE inhibitor therapy.

SOURCE(S)

American College of Cardiology, American Heart Association, Physician Consortium for Performance Improvement. Clinical performance measures. Chronic stable coronary artery disease. Chicago (IL): American Medical Association (AMA); 2003. 8 p.

Brief Abstract

DESCRIPTION

This measure assesses the percentage of chronic stable coronary artery disease (CAD) patients who also have diabetes and/or left ventricular systolic dysfunction (LVSD) who were prescribed angiotensin-converting enzyme (ACE) inhibitor therapy.

RATIONALE

Angiotensin-converting enzyme (ACE) inhibitor use is recommended in all patients with coronary artery disease (CAD) who also have diabetes and/or left ventricular systolic dysfunction (LVSD). ACE inhibitor use is also recommended in patients with CAD or other vascular disease (ACC/AHA, 2003).

PRIMARY CLINICAL COMPONENT

Coronary artery disease; Angiotensin-converting enzyme (ACE) inhibitor therapy

DENOMINATOR DESCRIPTION

All patients with coronary artery disease (CAD) who also have diabetes and/or left ventricular systolic dysfunction (LVSD)

NUMERATOR DESCRIPTION

The number of patients from the denominator who were prescribed angiotensin-converting enzyme (ACE) inhibitor therapy

Evidence Supporting the Measure

PRIMARY MEASURE DOMAIN

Process

SECONDARY MEASURE DOMAIN

Not applicable

EVIDENCE SUPPORTING THE MEASURE

A clinical practice guideline or other peer-reviewed synthesis of the clinical evidence
One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

NATIONAL GUIDELINE CLEARINGHOUSE LINK

- ACC/AHA 2002 guideline update for the management of patients with chronic stable angina: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Update the 1999 Guidelines for the Management of Patients With Chronic Stable Angina).

Evidence Supporting Need for the Measure

NEED FOR THE MEASURE

Overall poor quality for the performance measured
Wide variation in quality for the performance measured

EVIDENCE SUPPORTING NEED FOR THE MEASURE

Gibbons RJ, Abrams J, Chatterjee K, Daley J, Deedwania PC, Douglas JS, Ferguson TB Jr, Fihn SD, Fraker TD Jr, Gardin JM, O'Rourke RA, Pasternak RC, Williams SV. ACC/AHA 2002 guideline update for the management of patients with chronic stable angina. Summary article. J Am Coll Cardiol 2003 Jan 1;41(1):159-68.

Jencks SF, Huff ED, Cuerdon T. Change in the quality of care delivered to Medicare beneficiaries, 1998-1999 to 2000-2001. JAMA 2003 Jan 15;289(3):305-12.

State of Use of the Measure

STATE OF USE

Pilot testing

CURRENT USE

Internal quality improvement

Application of Measure in its Current Use

CARE SETTING

Ambulatory Care

PROFESSIONALS RESPONSIBLE FOR HEALTH CARE

Physicians

LOWEST LEVEL OF HEALTH CARE DELIVERY ADDRESSED

Individual Clinicians

TARGET POPULATION AGE

Patients of all ages with the diagnosis of chronic stable coronary artery disease.

TARGET POPULATION GENDER

Either male or female

STRATIFICATION BY VULNERABLE POPULATIONS

Not applicable

Characteristics of the Primary Clinical Component

INCIDENCE/PREVALENCE

- Approximately 13 million Americans are living with coronary artery disease (CAD).
- More than 1 million Americans had a new or recurrent coronary attack in 2001.

EVIDENCE FOR INCIDENCE/PREVALENCE

American Heart Association. Heart disease and stroke statistics - 2003 update. Dallas (TX): American Heart Association; 2002. 46 p.

ASSOCIATION WITH VULNERABLE POPULATIONS

Not applicable

BURDEN OF ILLNESS

- Chronic stable coronary artery disease (CAD) is the leading cause of mortality in the United States, accounting for almost 1 in 5 deaths.
- For individuals with CAD, the risk of another heart attack, stroke, and other serious complications is substantial.

EVIDENCE FOR BURDEN OF ILLNESS

American Heart Association. Heart disease and stroke statistics - 2003 update. Dallas (TX): American Heart Association; 2002. 46 p.

UTILIZATION

Within the past 2 decades, the number of short-stay hospital discharges for individuals with coronary artery disease (CAD) increased by almost 18%.

EVIDENCE FOR UTILIZATION

American Heart Association. Heart disease and stroke statistics - 2003 update. Dallas (TX): American Heart Association; 2002. 46 p.

COSTS

The total annual cost of coronary artery disease (CAD) in the United States is approximately $130 billion.

EVIDENCE FOR COSTS

American Heart Association. Heart disease and stroke statistics - 2003 update. Dallas (TX): American Heart Association; 2002. 46 p.

Institute of Medicine National Healthcare Quality Report Categories

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

Data Collection for the Measure

CASE FINDING

Users of care only

DESCRIPTION OF CASE FINDING

This performance measure is designed for prospective data collection in the office-based practice only. The measurement period may begin with the date of the most recent office visit, regardless of the diagnosis at that visit, and the data collection continues until 12 months are completed.

DENOMINATOR SAMPLING FRAME

Patients associated with provider

DENOMINATOR (INDEX) EVENT

Clinical Condition

DENOMINATOR INCLUSIONS/EXCLUSIONS

Inclusions
Patients with coronary artery disease (CAD) who also have diabetes and/or left ventricular systolic dysfunction (LVSD) (left ventricular ejection fraction less than 40% or moderately or severely depressed left ventricular systolic function)

Exclusions
Documentation that angiotensin-converting enzyme inhibitor (ACEI) was not indicated (e.g., patients on angiotensin receptor blockers [ARB]); documentation of medical reason(s)* for not prescribing ACE inhibitor; documentation of patient reason(s)** for not prescribing ACE inhibitor

*Medical reasons for not prescribing ACE inhibitor (ACEI): allergy, angioedema due to ACEI, anuric renal failure due to ACEI, pregnancy, moderate or severe aortic stenosis, etc.

**Patient reasons for not prescribing ACEI: economic, social, and/or religious, etc.

NUMERATOR INCLUSIONS/EXCLUSIONS

Inclusions
All patients who were prescribed angiotensin-converting enzyme (ACE) inhibitor therapy

Exclusions
None

DENOMINATOR TIME WINDOW

Time window follows index event

NUMERATOR TIME WINDOW

Fixed time period

DATA SOURCE

Medical record

LEVEL OF DETERMINATION OF QUALITY

Individual Case

PRE-EXISTING INSTRUMENT USED

None

Computation of the Measure

SCORING

Rate

INTERPRETATION OF SCORE

Better quality is associated with a higher score

ALLOWANCE FOR PATIENT FACTORS

Risk adjustment devised specifically for this measure/condition

DESCRIPTION OF ALLOWANCE FOR PATIENT FACTORS

Measure results may be calculated for both:

- All (including patients on angiotensin receptor blockers [ARBs]) patients with diabetes and/or left ventricular systolic dysfunction (LVSD) who were prescribed angiotensin converting enzyme (ACE) inhibitor therapy
- Patients with diabetes and/or LVSD who werer prescribed ACE inhibitor therapy, with all denominator exclusions* applied.

*Medical reasons for not prescribing ACE inhibitor (ACEI): allergy, angioedema due to ACEI, anuric renal failure due to ACEI, pregnancy, moderate or severe aortic stenosis, etc.

Patient reasons for not prescribing ACEI: economic, social, and/or religious, etc.

STANDARD OF COMPARISON

Internal time comparison

Evaluation of Measure Properties

EXTENT OF MEASURE TESTING

Unspecified

Identifying Information

ORIGINAL TITLE

ACE inhibitor therapy.

MEASURE COLLECTION

The Physician Consortium for Performance Improvement Measurement Sets

MEASURE SET NAME

American College of Cardiology, American Heart Association, and Physician Consortium for Performance Improvement: Chronic Stable Coronary Artery Disease Core Physician Performance Measurement Set

SUBMITTER

American Medical Association on behalf of the American College of Cardiology, the American Heart Association, and the Physician Consortium for Performance Improvement

DEVELOPER

American College of Cardiology
American Heart Association
Physician Consortium for Performance Improvement

ADAPTATION

Measure was not adapted from another source.

RELEASE DATE

2003 Jan

MEASURE STATUS

This is the current release of the measure.

SOURCE(S)

American College of Cardiology, American Heart Association, Physician Consortium for Performance Improvement. Clinical performance measures. Chronic stable coronary artery disease. Chicago (IL): American Medical Association (AMA); 2003. 8 p.

MEASURE AVAILABILITY

The individual measure, "ACE Inhibitor Therapy," is published in the "Chronic Stable Coronary Artery Disease Core Physician Performance Measurement Set." This document is available from the American Medical Association (AMA) Division of Clinical Quality Improvement Unit Web site: www.ama-assn.org/go/quality.

For further information, please contact AMA staff by e-mail at cqi@ama-assn.org.

COMPANION DOCUMENTS

The following are available:

- Physician Consortium for Performance Improvement. Introduction to physician performance measurement sets. Tools developed by physicians for physicians. Chicago (IL): American Medical Association (AMA); 2001 Oct. 21 p. This document is available from the American Medical Association (AMA) Clinical Quality Improvement Unit Web site: www.ama-assn.org/go/quality.
- Physician Consortium for Performance Improvement. Principles for performance measurement in health care. A consensus statement. [online]. Chicago (IL): American Medical Association (AMA), Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), National Committee for Quality Assurance (NCQA); [3 p]. This document is available from the AMA Clinical Quality Improvement Unit Web site: www.ama-assn.org/go/quality.
- Physician Consortium for Performance Improvement. Desirable attributes of performance measures. A consensus statement. [online]. American Medical Association (AMA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee for Quality Assurance (NCQA); 1999 Apr 19 [cited 2002 Jun 19]. [5 p]. This document is available from the AMA Clinical Quality Improvement Unit Web site: www.ama-assn.org/go/quality.

For further information, please contact AMA staff by e-mail at cqi@ama-assn.org.

NQMC STATUS

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